INFORMED BOTOX/DYSPORT/XEOMIN (REFERRED TO AS *NEUROTOXIN* IN FORM) INJECTION CONSENT FORM

I, _____ **(print name)** have the right to be informed about my skin condition, and treatment so that I may make an informed decision, whether or not to undergo the procedure after knowing the risks and hazards involved. Neurotoxin i.e. Botox is a product that has been on the market worldwide. It typically lasts 3 to 4 months; however, each patient responds differently to them. No guarantee can be made with regard to the result or the length of time it will last. Rarely, there may be swelling, discoloration (black and blue marks), and or drooping of the brow or lid that may persist for several weeks, but is generally temporary. _____ **(Please initial)**

Prior to treatment, a trained medical injector reviewed my complete medical history, examined me, reviewed the procedure and the technique he or she plans to use with me, and answered, to my best satisfaction, all questions I have regarding the treatment. Do not receive Neurotoxin if you: are allergic to any of the ingredients in neuromodulators); had an allergic reaction to any other botulinum toxin product such as Botox® (onabotulinumtoxinA), Dysport® (abobotulinumtoxinA), or Xeomin® (incobotulinumtoxinA); have a skin infection at the planned injection site. _____ **(Please initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by **BO BY YAS** the cost of supplies, and other related expenditures. Should complications develop from the procedure, additional costs may occur and will be the patient's financial responsibility. Additional Procedures, Supplies, Antibiotics, etc., will also be the patient's responsibility. _____ **(Please initial)**

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications. _____ **(Please initial)**

I consent to and authorize the healthcare facility located at **1061 N Dobson #110, Suite 19 Mesa, AZ 85201** to inject the above listed, to areas suggested. _____ **(Please initial)**

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatments, have been fully explained to me, I understand them, and I assume all responsibilities. dry mouth; discomfort or pain at the injection site; tiredness; headache; neck pain; and eye problems: double vision, blurred vision, decreased eyesight, drooping eyelids and eyebrows, swelling of your eyelids and dry eyes. _____ **(Please initial)**

I agree that this constitutes full disclosure, and that it supercedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions. _____ **(Please initial)**

ACKNOWLEDGEMENT:

I understand that the neurotoxin is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. I further agree that there are no refunds for missed appointments. _____ **(Please initial)**

Clinical results may vary; I acknowledge that no guarantee or assurance has been given by anyone as to the results, which may be obtained. _____ **(Please initial)**

I understand that all services that have been rendered are non-refundable. Packages that are cancelled within 5 days of payment will receive a refund; otherwise a credit towards other services will be issued. _____ **(Please initial)**

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have this office cover any questions or clarifications I might have prior to signing this consent and thereby grant **BO BY YAS practitioners** permission to perform aforementioned treatments on me**.**

Signature – Patient or Parent/Guardian Print Name Date

Witness _____